

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3181

CERTIFICATE OF DEATH

Reg. Dist. No.

03154

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAYRE DE GRACE (RURAL) 2 yrs				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL-HAYRE DE GRACE R.D.#2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HOME				d. STREET ADDRESS HOME			
3. NAME OF DECEASED (Type or print) First OMA Middle FAY Last ARBAUGH				4. DATE OF DEATH Month MARCH Day 9 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 24, 1937		9. AGE (In years last birthday) 21 yrs.		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME		11. BIRTHPLACE (State or foreign country) MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES JOHNSON				14. MOTHER'S MAIDEN NAME MINERVA E. WILSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT JOSEPH J. ARBAUGH, HAYRE DE GRACE, MD Address R.D.#2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EMBOLUS 682X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) THROMBO-PHLEBITIS DUE TO (c) POST PARTUM						INTERVAL BETWEEN ONSET AND DEATH 8 days 8 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 7-14 , 19 58 , to 3-9 , 19 59 , that I last saw the deceased alive on 3-9 , 19 59 , and that death occurred at 5:50 P M, from the causes and on the date stated above.							
ACTUAL SIGNATURE Georgette D. Hirsch M.D.				ADDRESS (Street, city or town, state) 421 CONGRESS AV.			
DATE SIGNED							
PHYSICIAN'S NAME (Type) GUNTHER D. HIRSCH				HAYRE DE GRACE MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR-13-1959		22c. NAME OF CEMETERY OR CREMATORY MT. ZION CEM.		22d. LOCATION (City, town, or county) (State) HARFORD MD	
23. FUNERAL DIRECTOR'S SIGNATURE R. Madison Mitchell				ADDRESS HAYRE DE GRACE MD		24a. REC'D BY REGISTRAR DATE MAR 13 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. K...			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MASSACHUSETTS DEPARTMENT OF HEALTH

3160

CERTIFICATE OF DEATH

03155

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				d. STREET ADDRESS <u>128 Rock Rd.</u>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ronald Carl Barnoff</u>				4. DATE OF DEATH Month Day Year <u>3 7 1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>7-3-58</u>	
9. AGE (In years lost birthday) yrs. <u>8</u>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>							
13. FATHER'S NAME <u>Eugene Frederick Barnoff</u>				14. MOTHER'S MAIDEN NAME <u>Evelyn DILTS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>—</u>			
17. INFORMANT <u>Eugene Barnoff</u>				Address <u>128 Rock Rd. Abt. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)]							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal bleeding</u> <u>540.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Peptic ulcer, acute</u> DUE TO (c) <u>Dehydration, acidosis, chemical imbalance</u>							
INTERVAL BETWEEN ONSET AND DEATH <u>12 hr.</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>August</u> , 19 <u>58</u> , to <u>3-7-</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>13-7-59</u> , and that death occurred at <u>7:25 PM</u> , from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) <u>8 Law Street</u>				DATE SIGNED			
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.							
PHYSICIAN'S NAME (Type) <u>Peter P. Rodman, M.D.</u>				Aberdeen, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/11/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Circle Hill Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Fairview, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John G. Barnoff</u> ADDRESS <u>Aberdeen, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1925

1925

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. PLACE OF DEATH		9. TIME OF DEATH		10. SIGNATURE OF REGISTRAR		11. SIGNATURE OF DECEASED		12. SIGNATURE OF WITNESSES		13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF CLERGYMAN		15. SIGNATURE OF BURIAL OFFICIAL		16. SIGNATURE OF FUNERAL HOME		17. SIGNATURE OF CEMETERY		18. SIGNATURE OF OTHER		19. SIGNATURE OF OTHER		20. SIGNATURE OF OTHER		21. SIGNATURE OF OTHER		22. SIGNATURE OF OTHER		23. SIGNATURE OF OTHER		24. SIGNATURE OF OTHER		25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER		28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER		31. SIGNATURE OF OTHER		32. SIGNATURE OF OTHER		33. SIGNATURE OF OTHER		34. SIGNATURE OF OTHER		35. SIGNATURE OF OTHER		36. SIGNATURE OF OTHER		37. SIGNATURE OF OTHER		38. SIGNATURE OF OTHER		39. SIGNATURE OF OTHER		40. SIGNATURE OF OTHER		41. SIGNATURE OF OTHER		42. SIGNATURE OF OTHER		43. SIGNATURE OF OTHER		44. SIGNATURE OF OTHER		45. SIGNATURE OF OTHER		46. SIGNATURE OF OTHER		47. SIGNATURE OF OTHER		48. SIGNATURE OF OTHER		49. SIGNATURE OF OTHER		50. SIGNATURE OF OTHER		51. SIGNATURE OF OTHER		52. SIGNATURE OF OTHER		53. SIGNATURE OF OTHER		54. SIGNATURE OF OTHER		55. SIGNATURE OF OTHER		56. SIGNATURE OF OTHER		57. SIGNATURE OF OTHER		58. SIGNATURE OF OTHER		59. SIGNATURE OF OTHER		60. SIGNATURE OF OTHER		61. SIGNATURE OF OTHER		62. SIGNATURE OF OTHER		63. SIGNATURE OF OTHER		64. SIGNATURE OF OTHER		65. SIGNATURE OF OTHER		66. SIGNATURE OF OTHER		67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER		70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER		73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER		76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER		79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER		82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER		85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER		88. SIGNATURE OF OTHER		89. SIGNATURE OF OTHER		90. SIGNATURE OF OTHER		91. SIGNATURE OF OTHER		92. SIGNATURE OF OTHER		93. SIGNATURE OF OTHER		94. SIGNATURE OF OTHER		95. SIGNATURE OF OTHER		96. SIGNATURE OF OTHER		97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER		100. SIGNATURE OF OTHER	
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3182

CERTIFICATE OF DEATH

03156

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rocks</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>VIRGIE ANN BLEVINS</u>				4. DATE OF DEATH Month Day Year <u>March 25 19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 16, 1887</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Harford Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Peter Harman</u>				14. MOTHER'S MAIDEN NAME <u>MARY B. Steine</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Robert M. Blevins Rocks Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Obstruction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Atherosclerosis</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 24, 1959</u> to <u>March 26, 1959</u> , that I last saw the deceased alive on <u>March 24, 1959</u> , and that death occurred at <u>5 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Benjamin Dorogi</u> M.D. PHYSICIAN'S NAME (Type) <u>BENJAMIN DOROGI, M.D.</u> <u>Cardiff, Md.</u>				ADDRESS (Street, city or town, state) <u>Corroiff</u> DATE SIGNED <u>3/25/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/28/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Pylesville Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Kurtz</u> ADDRESS <u>Farrettsville, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles E. Kurtz</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										03157
Items 18&19 Film 242 5-7-59 ams										
3161										
CERTIFICATE OF DEATH										
Reg. Dist. No.										
1. PLACE OF DEATH a. COUNTY Harford MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Indiana b. COUNTY Unknown					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen					c. LENGTH OF STAY IN 1b Edinburg 52x-3					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Aberdeen Road					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First EDWARD Middle RAYMOND Last BRONISZEWSKI					4. DATE OF DEATH Month March Day 20 Year 19 59					
5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 24 October 1922		9. AGE (In years lost birthday) 36 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Army		10b. KIND OF BUSINESS OR INDUSTRY US Army		11. BIRTHPLACE (State or foreign country) Indiana		12. CITIZEN OF WHAT COUNTRY? United States				
13. FATHER'S NAME Kasmir D Broniszewski					14. MOTHER'S MAIDEN NAME Unknown					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WWII Korean					16. SOCIAL SECURITY NO. 342-12-0403					
17. INFORMANT Official Army Records					Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple lacerations, fracture, Hemorrhage, intraperitoneal and fracture, manebrium DUE TO (b) manebrium DUE TO (c) manebrium Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost.										INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driver of vehicle which collided into a tree.					
20c. TIME OF INJURY Month, Day, Year Hour 2:05 AM Mar 20 19 59					20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>					
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Street					20f. (City or town) (County) (State) Aberdeen Harford Md					
21. I certify that I attended the deceased from DOA, 20 Mar, 19 59, to Mar 20 19 59 , that I last saw the deceased alive on never , 19 59 , and that death occurred at 2:05 AM , from the causes and on the date stated above.										
ACTUAL SIGNATURE Robert L Corn, Capt					ADDRESS (Street, city or town, state) USAH, APG, Md.					
PHYSICIAN'S NAME (Type) ROBERT L CORN CAPT MC					DATE SIGNED					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal			22b. DATE THEREOF 3-21-59		22c. NAME OF CEMETERY OR CREMATORY Edinburg, Indiana			22d. LOCATION (City, town, or county) (State) Edinburg, Indiana		
23. FUNERAL DIRECTOR'S SIGNATURE William Cook-Blight, Inc. Baltimore, Maryland					24a. REC'D BY REGISTRAR MAR 26 59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

CERTIFICATE OF DEATH

UNITED STATES DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

For use in

State of NEW YORK

County of NEW YORK

City of NEW YORK

Age 25

Sex Male

Date of Birth 1910

Place of Birth NEW YORK

Usual Residence NEW YORK

Occupation Student

Married Never

Usual Residence NEW YORK

Sex Male

Age 25

Date of Birth 1910

Place of Birth NEW YORK

Usual Residence NEW YORK

Occupation Student

Married Never

Usual Residence NEW YORK

Occupation Student

Date of Birth 1910

Sex Male

Usual Residence NEW YORK

Married Never

Usual Residence NEW YORK

Occupation Student

Date of Birth 1910

Sex Male

Age 25

Place of Birth NEW YORK

Usual Residence NEW YORK

Occupation Student

Date of Birth 1910

Usual Residence NEW YORK

Occupation Student

Sex Male

Married Never

Usual Residence NEW YORK

Date of Birth 1910

Place of Birth NEW YORK

Usual Residence NEW YORK

Occupation Student

Date of Birth 1910

Sex Male

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03158

3183
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Monkton RD Taylor</u>		c. LENGTH OF STAY IN 1b <u>40 yrs</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ANNA</u> Middle <u>MATILDA</u> Last <u>Cochran</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>16</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Mar. 31, 1901</u>
9. AGE (In years lost birthday) <u>57 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Baltimore City, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Theodore Werneke</u>		14. MOTHER'S MAIDEN NAME <u>Catherine Nabor</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>----</u>	
17. INFORMANT <u>Harry W. Cochran</u>		Address <u>Monkton, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>581.1</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Lanquac's Cirrhosis</u> DUE TO <u>6 mos</u> (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Cardiovascular Disease</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>JUNE</u> , 19 <u>59</u> , to <u>16 MAR.</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>15 MAR.</u> , 19 <u>59</u> , and that death occurred at <u>3:55 A.</u> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Thos. A. E. Moseley, M.D.</u> <u>Jarrettsville, Md.</u> <u>3/16/59</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>THOS. A. E. MOSELEY, JR.</u> <u>JARRETSVILLE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/18/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Johns</u>		22d. LOCATION (City, town, or county) (State) <u>Hydes Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles E. Furtz</u>		24a. REC'D BY REGISTRAR <u>MAR 18 '59</u>	
ADDRESS <u>Jarrettsville, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03159

3162

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air				c. LENGTH OF STAY IN 1b 4 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jarrettsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Convalescent Home				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Fredrick Last Denbow			4. DATE OF DEATH Month March Day 24 Year 1959				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 28, 1869		9. AGE (In years last birthday) 89 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Thomas Denbow				14. MOTHER'S MAIDEN NAME Catherine Stritehoff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Willard Denbow, Jarrettsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Head of Pancreas 157X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chr. Cardio-Vascular Disease.							INTERVAL BETWEEN ONSET AND DEATH ?
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 11 , 19 59 , to March 24 , 19 59 , that I last saw the deceased alive on March 23 , 19 59 , and that death occurred at 8:00 PM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Forest Hill, Maryland DATE SIGNED March 25, 1959							
ACTUAL SIGNATURE Willard P. Hudson				PHYSICIAN'S NAME (Type) Willard P. Hudson, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/1959		22c. NAME OF CEMETERY OR CREMATORY Bethel		22d. LOCATION (City, town, or county) (State) Madonna Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kurtz				ADDRESS Jarrettsville, Md.		24a. REC'D BY REGISTRAR MAR 30 '59	
						24b. REGISTRAR'S SIGNATURE Arthur S. Hays	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

<p>1. NAME OF DECEASED <u>JOHN J. HARRIS</u></p>		<p>2. SEX <u>Male</u></p>		<p>3. AGE <u>65</u></p>	
<p>4. DATE OF DEATH <u>April 15, 1945</u></p>		<p>5. TIME OF DEATH <u>10:30 AM</u></p>		<p>6. PLACE OF DEATH <u>Home</u></p>	
<p>7. OCCUPATION <u>Retired</u></p>		<p>8. MARITAL STATUS <u>Married</u></p>		<p>9. PLACE OF BIRTH <u>Baltimore, Md.</u></p>	
<p>10. CAUSE OF DEATH <u>Heart Disease</u></p>		<p>11. MANNER OF DEATH <u>Natural</u></p>		<p>12. SIGNATURE OF PHYSICIAN <u>Dr. J. H. Smith</u></p>	
<p>13. SIGNATURE OF REGISTRAR <u>John J. Harris</u></p>		<p>14. SIGNATURE OF WITNESSES <u>John J. Harris</u></p>		<p>15. SIGNATURE OF DECEASED <u>John J. Harris</u></p>	

CERTIFICATE OF DEATH

Reg. Dist. No.

3163

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVRE DE GRACE</u>		c. LENGTH OF STAY IN 1b <u>33 DAYS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Edgewood</u> Rural	
3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>G</u> Last <u>DURMAN</u>		4. DATE OF DEATH Month <u>MARCH</u> Day <u>26</u> Year <u>1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan. 31, 1915</u>
9. AGE (In years lost birthday) <u>44</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sand & Gravel</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JAMES H. DURMAN</u>		14. MOTHER'S MAIDEN NAME <u>MARGARET FOX</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW 11</u>		16. SOCIAL SECURITY NO. <u>215-05-3873</u>	
17. INFORMANT <u>Dorothy M. Durman</u>		Address <u>Edgewood R.D., Maryland.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic shock</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bleeding esophageal varices</u> DUE TO (c) <u>Embolus of liver</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2-21</u> , 19 <u>59</u> , to <u>3-25</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-25</u> , 19 <u>59</u> , and that death occurred at <u>3:30</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Wm. K. Brendle</u>		M.D. <u>610 S. Union Ave., Havre de Grace, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Wm., K. Brendle</u>		<u>610 S. Union Ave., Havre de Grace, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3/29/1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Southern</u>	22d. LOCATION (City, town, or county) (State) <u>Dublin, Harford, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard R. Williams Jr.</u>		ADDRESS <u>Abingdon, Md.</u>	24a. REC'D BY REGISTRAR DATE <u>MAR 31 '59</u>
		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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3/26/79

mentuoS

Dublin, Harford, Maryland

Wm. K. Brendle

Old 3. Union Ave., N. York, N. Y.

610 E. Union Ave., Havre de Grace, Md.

2/10/75

3164
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAURE DE GRACE</u>				c. LENGTH OF STAY IN 1b <u>13 DAYS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSP.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
4. DATE OF DEATH First Middle Last <u>Florence Caudill Edwards</u> Month Day Year <u>MARCH 10 19 59</u>				5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>JAN 7 - 1882</u> 9. AGE (In years last birthday) yrs. <u>77</u> IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>✓</u>			
11. BIRTHPLACE (State or foreign country) <u>NORTH CAROLINA</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>TYCELL CAUDILL</u>				14. MOTHER'S MAIDEN NAME <u>CARDINE FENDER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>✓</u> (If yes, give year or dates of service) <u>✓</u>				16. SOCIAL SECURITY NO. <u>✓</u>			
17. INFORMANT <u>Mr. Fulford</u> Address <u>111 Fulford Ave Bel Air Md</u>							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>443X</u> DUE TO <u>Hypertensive and arteriosclerotic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cardiovascular Disease</u> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>2/25</u> , 19 <u>59</u> , to <u>3/10</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>March 10th</u> , 19 <u>59</u> , and that death occurred at <u>5:35</u> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edward C. Loo, M.D.</u>				ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u> DATE SIGNED <u>3/10/59</u>			
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>				LOCATION (City, town, or county) (State) <u>Harford Whitehead Xc.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>MAR 13/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Baptist</u>		22d. LOCATION (City, town, or county) (State) <u>Harford Whitehead Xc.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Futer</u> ADDRESS <u>W. Broadway + Williams St. BEL AIR, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 12 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03162

3184

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Hanford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Hanford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Perryman</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Perryman</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>#17 Maple Ave.</i>		d. STREET ADDRESS <i>17 Maple Ave.</i>	
3. NAME OF DECEASED (Type or print) <i>Bertie Lee Eichelberger</i>		4. DATE OF DEATH Month <i>3</i> Day <i>17</i> Year <i>1959</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/7/1917</i>
9. AGE (In years last birthday) <i>42</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Seymour Ayers</i>		14. MOTHER'S MAIDEN NAME <i>Harvey Letterman</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>241-26-9001</i>	
17. INFORMANT <i>Thomas Robert Eichelberger</i>		Address <i>Perryman Md. 17 Maple Ave</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>CARCINOMATOSIS</i> <i>151X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>CARCINOMA OF STOMACH</i> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <i>1 MONTH</i> <i>2 MONTHS</i>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>ASCITES</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <i>1/5</i> , 19 <i>59</i> , to <i>3/17</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>3/16</i> , 19 <i>59</i> , and that death occurred at <i>11:45</i> M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <i>C. W. Stewart Jr.</i> M.D. <i>Box 95, Edgewood, Md.</i> PHYSICIAN'S NAME (Type) <i>C. W. STEWART, JR.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/20/1959</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Bel Air Memorial Gardens, Bel Air Maryland</i>		22d. LOCATION (City, town, or county) (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Garrison Aberdeen, Maryland</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 20 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoma</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3165

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>HARFORD</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>HARFORD</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVREDE GRACE</u>				c. LENGTH OF STAY IN 1b <u>36 days.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD MEMORIAL HOSPITAL</u>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Belair</u>			
f. STREET ADDRESS <u>411 S Kenmore St.</u>				g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>C</u> Last <u>Engel Jr</u>				4. DATE OF DEATH Month <u>March</u> Day <u>8</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JANUARY 31, 1959</u>	
9. AGE (In years last birthday) yrs. <u>36</u>		IF UNDER 1 YEAR Months <u>36</u> Days <u>36</u> Hours <u>36</u> Min. <u>36</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME <u>HARRY C Engel Jr.</u>			
14. MOTHER'S MAIDEN NAME <u>Ethel Burkins</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			
16. SOCIAL SECURITY NO. <u>None</u>				17. INFORMANT <u>HARRY C Engel Jr</u> Address <u>411 S Kenmore St Belair Harford Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CONGENITAL HEART DISEASE</u> <u>754.2</u> DUE TO <u>(TRUNCUS ARTERIOSUS + INTERVENTRICULAR SEPTAL DEFECT)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____				21. I certify that I attended the deceased from <u>1/31/59</u> , 19 <u>59</u> , to <u>3/8</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/7</u> , 19 <u>59</u> , and that death occurred at <u>7:30</u> A.M., from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) _____				DATE SIGNED <u>3/8/59</u>			
ACTUAL SIGNATURE <u>Wm. K. Brendle</u> M.D. <u>Harford Md</u>				PHYSICIAN'S NAME (Type) _____			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR 9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>BEL AIR MEMORIAL GARDENS</u>		22d. LOCATION (City, town, or county) <u>Bel Air Harford Md</u> (State) _____	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Finto</u> ADDRESS <u>Bel Air Md</u>				24a. REC'D BY REGISTRAR <u>DATE MAR 10 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clifford E. Hanna</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2071272XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03164

3185
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bel Air		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 Bel Air	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Box 401, Moores Mill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First DAVID Middle MADISON Last ESTES		4. DATE OF DEATH Month March Day 14 Year 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 13 Nov. 1880
9. AGE (In years last birthday) yrs. 78		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lumberman		10b. KIND OF BUSINESS OR INDUSTRY Lumber Business, North Carolina	
11. BIRTHPLACE (State or foreign country) USA.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Boone Estes		14. MOTHER'S MAIDEN NAME Rachel A. Moore	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 218-32-4169	
17. INFORMANT Mrs. Raymond Howell		Address Rt #1, Box 176 Joppa, Maryland	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PULMONARY EDEMA A-CARDIO RESP FAILURE DUE TO 443X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) HYPERTENSIVE CARDIOVASCULAR DISEASE DUE TO ARTERIO SCLEROSIS (c) 5 YRS		INTERVAL BETWEEN ONSET AND DEATH 1 HOUR SEVERAL YEARS	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from JAN 19 56 to MAR 19 59 , that I last saw the deceased alive on 14 MARCH 19 59 , and that death occurred at 1:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE H. P. Sidwell		ADDRESS (Street, city or town, state) 401 Franklin St. DATE SIGNED 14 MAR 59	
PHYSICIAN'S NAME (Type) Harvey P. Sidwell, M.D.		Bel Air, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 3/16/1959	22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Garden, Bel Air, Maryland	22d. LOCATION (City, town, or county) (State)
23. FUNERAL DIRECTOR'S SIGNATURE John P. Tarring		24a. REC'D BY REGISTRAR DATE MAR 18 '59	24b. REGISTRAR'S SIGNATURE Arthur L. Kline

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

Name of Deceased		Sex		Age	
Date of Birth		Date of Death		Place of Death	
Cause of Death		Manner of Death		Occupation	
Signature of Physician		Signature of Registrar		Signature of Informant	
Date of Certificate		Date of Registration		Date of Filing	
County		City		Town	
State		Zip		Country	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3186

CERTIFICATE OF DEATH

03166

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Benson		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Harford Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Anna First N. Middle Hays Last		4. DATE OF DEATH Month 3 Day 25 Year 1959	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 20, 1884
9. AGE (In years last birthday) 74 yrs.		10. IF UNDER 1 YEAR Months 7 Days 4 Hours 15 Min.	11. IF UNDER 24 HRS. Months 7 Days 4 Hours 15 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Housework	
11. BIRTHPLACE (State or foreign country) Fallston, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Noble Mitchell		14. MOTHER'S MAIDEN NAME Elva Cannon	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) ---		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Donald H. Hays Address Benson, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma left arm with metastases to 199.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) chest. DUE TO (c) 7 mos.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Ovarium cyst. Prolapse of uterus.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) -----	
20c. TIME OF INJURY Month, Day, Year Hour o. m. ----- p. m. -----		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) -----		20f. (City or town) ----- (County) ----- (State) -----	
21. I certify that I attended the deceased from January 22, 1958 , to March 25, 1959 , that I last saw the deceased alive on March 23, 1959 , and that death occurred at 12:30 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Fork, Maryland DATE SIGNED 3/25/59	
ACTUAL SIGNATURE Clifford F. Hudson, M.D.		PHYSICIAN'S NAME (Type) Clifford F. Hudson, M.D. Fork, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/27/59	
22c. NAME OF CEMETERY OR CREMATORY Friendship Methodist		22d. LOCATION (City, town, or county) (State) Fallston, Harford, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster ADDRESS W. Broadway + Williams St. Bel Air, Maryland		24a. REC'D BY REGISTRAR DATE MAR 30 '59	
24b. REGISTRAR'S SIGNATURE Clifford F. Hudson			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

3128

MADE IN

STATE OF NEW YORK

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel-Air</i>	c. LENGTH OF STAY IN 1b <i>Lifetime</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel-Air</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>R.F.W. 1 Box # 282</i>		d. STREET ADDRESS <i>R.F.W. 1 Box # 282</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Thomas</i> Middle <i>B.</i> Last <i>Hill</i>		4. DATE OF DEATH Month <i>3</i> - Day <i>14</i> , Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct. 5, 1883</i>
9. AGE (In years last birthday) <i>75</i> yrs.		IF UNDER 1 YEAR Months <i>5</i> Days <i>9</i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Farm Worker + Janitor</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Farm + Board of Education</i>	
11. BIRTHPLACE (State or foreign country) <i>Bel-Air, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>Gable Jackson Hill</i>		14. MOTHER'S MAIDEN NAME <i>Febey Bond</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>Mrs. Hattie R. Hill</i>		Address <i>Rt-1 Box 282, Bel-Air, Md.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pulmonary Embolus</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Phlebitis, Right Leg</i> DUE TO (c) <i></i>			INTERVAL BETWEEN ONSET AND DEATH <i>10 minutes</i> <i>3 1/2 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i></i>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m. <i></i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Dec. 19, 47</i> to <i>MAR. 14, 1959</i> , that I last saw the deceased alive on <i>MAR. 14, 1959</i> , and that death occurred at <i>5:30 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Robert Barthel</i>		ADDRESS (Street, city or town, state) <i>Forest Hill, Md.</i> DATE SIGNED <i>3/14/59</i>	
PHYSICIAN'S NAME (Type) <i>Robert Barthel</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>3-17-59</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Clark's Chapel Cem.</i>	22d. LOCATION (City, town, or county) (State) <i>Bel-Air, Harford Co., Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Bullock - Home de Grace</i>		24a. REC'D BY REGISTRAR <i>MAR 18 59</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thoma</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ARMY AND NAVY DEPARTMENT OF HEALTH-BALTIMORE, MD

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

03168

3168

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Harford</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hane de Grace</i>		c. LENGTH OF STAY IN IB <i>lifetime</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>24 Hane de Grace</i>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>389 Wilson St.</i>	
d. STREET ADDRESS <i>1389 Wilson St.</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Damon</i> Middle <i>R.</i> Last <i>Hinton</i>		4. DATE OF DEATH Month <i>3</i> Day <i>18</i> Year <i>1959</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan. 24, 1959</i>
9. AGE (In years last birthday) yrs. <i>2</i> Months <i>2</i> Days <i>22</i>		IF UNDER 1 YEAR IF UNDER 24 HRS. Hours <i>2</i> Min. <i>12</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>none</i>	
11. BIRTHPLACE (State or foreign country) <i>Hane de Grace, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>James E. Hinton</i>		14. MOTHER'S MAIDEN NAME <i>Sylvia Adams</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>—</i> (If yes, give war or dates of service) <i>—</i>		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT <i>Rev. James E. Hinton, Hane de Grace, Md.</i>		Address <i>389 Wilson St.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchial Pneumonia</i> <i>491X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>—</i> DUE TO (c) <i>—</i>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>—</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m. <i>—</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Jan.</i> , 19 <i>59</i> , to <i>March 18</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>March 18</i> , 19 <i>59</i> , and that death occurred at <i>8:30 P. M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George T. Stansbury</i>		ADDRESS (Street, city or town, state) <i>569 Revolution St. Hane de Grace, Md.</i>	
PHYSICIAN'S NAME (Type) <i>George T. Stansbury</i>		DATE SIGNED <i>3/20/59</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3-20-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>St. James Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Hane de Grace, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Oliver B. Bullock</i>		ADDRESS <i>Hane de Grace, Md.</i>	
24a. REC'D BY REGISTRAR <i>MAR 23 59</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Hume</i>	

2071345XV6

CERTIFICATE OF DEATH

188

MARRIED

Blank certificate form with horizontal lines for text entry.

03169

3169 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY Harford		MARYLAND		STATE Maryland		COUNTY Harford	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bel Air		LENGTH OF STAY (in this place) 52yrs.		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN Bel Air			
HOSPITAL OR INSTITUTION OR STREET ADDRESS 54 Lee St.				STREET ADDRESS (If rural give location) 54 Lee St.			
3. NAME OF DECEASED (Type or Print) (First) Beatrice (Middle) L. (Last) Howard				4. DATE OF DEATH (Month) 3 (Day) 19 (Year) 59			
5. SEX F	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) W	8. DATE OF BIRTH 7/20/1884		9. AGE last birthday 74yr yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY Housework		11. BIRTHPLACE (State or foreign country) Baltimore County, Md.		12. CITIZEN OF WHAT COUNTRY? USA.
13. FATHER'S NAME Albert M. League				14. MOTHER'S MAIDEN NAME Sallie P. Magness			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No		16. SOCIAL SECURITY NO. 214-26-0346		17. INFORMANT & ADDRESS Mrs. Marie H. Reith, 54 Lee St. Bel Air, Md.			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
422.1 IMMEDIATE CAUSE (A) Cerebral hemorrhage						12 hours	
ANTECEDENT CAUSE(S) DUE TO (B) Cerebral arteriosclerosis						1 or 2 yrs.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) Arteriosclerotic cardiovascular disease						5 - 8 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?					
22. I hereby certify that I attended the deceased from March 16, 1959 , to March 19, 1959 , that I last saw the deceased alive on March 18, 1959 , and that death occurred at 6:30 P. M, from the causes and on the date stated above.							
SIGNATURE Paul S. Stonesifer, Jr.				ADDRESS (Street, city, town, state) M.D. 115 Fulford Ave. Bel Air, Md.		DATE SIGNED 3/20/59	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		DATE THEREOF 3/22/59		NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		LOCATION (City, town, or county) (State) Bel Air, Md.	
24. REC'D BY REGISTRAR DATE MAR 23 '59		REGISTRAR'S SIGNATURE Arthur S. Kneass		25. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Fater ADDRESS W. Broadway & Williams St. BEL AIR, Maryland			

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

CERTIFICATE OF DEATH

1910

1. NAME OF DECEASED

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. DATE OF DEATH

13. PLACE OF DEATH

14. TIME OF DEATH

15. SIGNATURE OF PHYSICIAN

16. SIGNATURE OF REGISTRAR

17. DATE OF DEATH

18. PLACE OF DEATH

19. TIME OF DEATH

20. SIGNATURE OF PHYSICIAN

21. SIGNATURE OF REGISTRAR

22. DATE OF DEATH

23. PLACE OF DEATH

24. TIME OF DEATH

25. SIGNATURE OF PHYSICIAN

26. SIGNATURE OF REGISTRAR

27. DATE OF DEATH

28. PLACE OF DEATH

29. TIME OF DEATH

30. SIGNATURE OF PHYSICIAN

31. SIGNATURE OF REGISTRAR

32. DATE OF DEATH

33. PLACE OF DEATH

34. TIME OF DEATH

35. SIGNATURE OF PHYSICIAN

36. SIGNATURE OF REGISTRAR

37. DATE OF DEATH

38. PLACE OF DEATH

39. TIME OF DEATH

40. SIGNATURE OF PHYSICIAN

41. SIGNATURE OF REGISTRAR

42. DATE OF DEATH

43. PLACE OF DEATH

44. TIME OF DEATH

45. SIGNATURE OF PHYSICIAN

46. SIGNATURE OF REGISTRAR

47. DATE OF DEATH

48. PLACE OF DEATH

49. TIME OF DEATH

50. SIGNATURE OF PHYSICIAN

51. SIGNATURE OF REGISTRAR

52. DATE OF DEATH

53. PLACE OF DEATH

54. TIME OF DEATH

55. SIGNATURE OF PHYSICIAN

56. SIGNATURE OF REGISTRAR

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70. SIGNATURE OF PHYSICIAN

71. SIGNATURE OF REGISTRAR

72. DATE OF DEATH

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75. SIGNATURE OF PHYSICIAN

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79. TIME OF DEATH

80. SIGNATURE OF PHYSICIAN

81. SIGNATURE OF REGISTRAR

82. DATE OF DEATH

83. PLACE OF DEATH

84. TIME OF DEATH

85. SIGNATURE OF PHYSICIAN

86. SIGNATURE OF REGISTRAR

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90. SIGNATURE OF PHYSICIAN

91. SIGNATURE OF REGISTRAR

92. DATE OF DEATH

93. PLACE OF DEATH

94. TIME OF DEATH

95. SIGNATURE OF PHYSICIAN

96. SIGNATURE OF REGISTRAR

97. DATE OF DEATH

98. PLACE OF DEATH

99. TIME OF DEATH

100. SIGNATURE OF PHYSICIAN

101. SIGNATURE OF REGISTRAR

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03170

3170

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <u>Bel Air</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford</u>		c. LENGTH OF STAY IN 1b <u>8 months</u> 32 <u>Bel Air</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Alice Ann St</u>		d. STREET ADDRESS <u>Alice Ann St</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Mary</u> First <u>C</u> Middle <u>Johnson</u> Last		4. DATE OF DEATH <u>March 19</u> 19 <u>59</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>C</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Jan 1-1913</u> 46 yrs.
9. AGE (In years last birthday) <u>46</u>		IF UNDER 1 YEAR	IF UNDER 24 HRS.
		Months	Days
		Hours	Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Bel Air Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>			
13. FATHER'S NAME <u>S Ridgely Johnson</u>		14. MOTHER'S MAIDEN NAME <u>Blanche Ruff</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give way or dates of service)		16. SOCIAL SECURITY NO. <u>Bel Air Rd Md</u>	
17. INFORMANT <u>Mrs Elizabeth J. Whittington</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> <u>442x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Bronchopneumonia</u> DUE TO (c) <u>Hypertensive C.V.R. Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> <u>2 days</u> <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md</u> DATE SIGNED <u>3-19-59</u>	
EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAR 23/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Hendon Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Bel Air Harford Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph W. Foster</u> W. Broadway + Willis Arms St. <u>Bel Air, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 23 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knaus</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 3,5 Film 6242 5-6-59 et

3166

CERTIFICATE OF DEATH

04401

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE	
c. LENGTH OF STAY IN 1b 3 HRS.		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL HOSP.	
d. STREET ADDRESS 331 N. Ohio		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Barry Earl Amos Kelly Jr.		4. DATE OF DEATH MARCH 24 1959	
5. SEX Male		6. COLOR OR RACE Colored	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH MARCH 24, 1959	
9. AGE (In years last birthday) 3		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. 3 2	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEW BORN INFANT		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME AMOS MARION KELLY	
14. MOTHER'S MAIDEN NAME FRANCES LORETTA ADAMS		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>	
16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776x Prematurity DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 3/24 , 19 59 , to 3/24 , 19 59 , that I last saw the deceased alive on 3/24 , 19 59 , and that death occurred at 10:50 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE George J. Stansbury		P ADDRESS (Street, city or town, state) 569 Revolution St. Haure de Grace, Md	
PHYSICIAN'S NAME (Type) George T. Stansbury		DATE SIGNED 3/25/59	
22a. BURIAL, CREMATION, or other disposition (Specify) buried		22b. DATE THEREOF 3-24-59	
22c. NAME OF CEMETERY OR CREMATORY Harford Memorial Hospital		22d. LOCATION (City, town, or county) (State) Haure de Grace Md	
23. FUNERAL DIRECTOR'S SIGNATURE Harry R. Kelly Administrator		ADDRESS	
24a. REC'D BY REGISTRAR DATE MAR 31 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Evans	

2071211XV0

CERTIFICATE OF DEATH

1. NAME OF DECEASED LARRY HARRIS		2. SEX Male	
3. AGE 38		4. DATE OF BIRTH 11/11/1940	
5. PLACE OF BIRTH BALTIMORE, MARYLAND		6. OCCUPATION LABORER	
7. MARITAL STATUS Married		8. DATE OF MARRIAGE 05/15/1965	
9. NAME OF SPOUSE JANE HARRIS		10. ADDRESS 1234 E. BALTIMORE AVE BALTIMORE, MD 21201	
11. CAUSE OF DEATH HEART DISEASE		12. PLACE OF DEATH HOME	
13. DATE OF DEATH 01/15/1979		14. TIME OF DEATH 10:00 AM	
15. SIGNATURE OF PHYSICIAN [Signature]		16. SIGNATURE OF REGISTRAR [Signature]	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3167

CERTIFICATE OF DEATH

03165

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> <u>Maryland</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harford Chase</u>				c. LENGTH OF STAY IN 1b <u>40 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Antonio</u> Middle <u>Leamone</u> Last <u>Leamone</u>				4. DATE OF DEATH Month <u>3/12/59</u> Day <u>19</u> Year <u>19</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> ? DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/3/1876</u>		9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Storekeeper</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Store</u>		11. BIRTHPLACE (State or foreign country) <u>Italy</u>	
13. FATHER'S NAME <u>Patrick Leamone</u>				14. MOTHER'S MAIDEN NAME <u>Angelia ?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unknown</u>				16. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Elizabeth Simone</u> Address <u>833 Euc</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 PULMONARY EDEMA</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <u>CORONARY OCCLUSION</u> DUE TO (c) <u>HYPERTENSIVE ARTERIOSCLEROTIC DISEASE 10 YRS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>ONE HR</u> <u>ONE DAY</u> <u>10 YRS</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>DIABETES MELLITUS</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>2/10, 1959</u> , to <u>3/12, 1959</u> , that I last saw the deceased alive on <u>3/12, 1959</u> , and that death occurred at <u>8:01</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irwin R. Ross</u>				ADDRESS (Street, city or town, state) <u>200 N Union Ave</u> DATE SIGNED <u>3/15/59</u>			
PHYSICIAN'S NAME (Type) <u>IRWIN R. ROSS</u>				<u>HOURE DE GRAVE, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>3/16/59</u>		<u>St. Euse</u>		<u>Harford Chase Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. P. Harford Chase, Md.</u>				ADDRESS		24a. REC'D BY REGISTRAR DATE <u>MAR 18 '59</u>	
						24b. REGISTRAR'S SIGNATURE <u>Arthur P. H.</u>	

CERTIFICATE OF DEATH

WILLIAM BROWN

DECEASED

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3171

CERTIFICATE OF DEATH

Reg. Dist. No.

03171

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harve de Grace</u>				c. LENGTH OF STAY IN 1b <u>9 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Baby Bay</u> Middle <u>McLadden</u> Last <u>McLadden</u>				4. DATE OF DEATH Month <u>March</u> Day <u>1</u> Year <u>1959</u>			
5. SEX <u>male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 1, 1959</u>	
9. AGE (In years last birthday) yrs. <u>9</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Lawrence McLadden</u>				14. MOTHER'S MAIDEN NAME <u>Edith Bayle</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mother</u> Address <u>Lawrence Trailer Park -</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity</u> <u>776X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>9 hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-1-59</u> , to <u>3-1-59</u> , that I last saw the deceased alive on <u>3-1-59</u> , and that death occurred at <u>1:00 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>860 W. 31st St. Aberdeen, Md.</u> DATE SIGNED <u>3-1-59</u>							
ACTUAL SIGNATURE <u>Peter P. Rodman</u> M.D.				PHYSICIAN'S NAME (Type) <u>Peter P. Rodman</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>3-1-59</u>		22b. DATE THEREOF <u>3-1-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL HOSPITAL</u>		22d. LOCATION (City, town, or county) (State) <u>Harve de Grace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harry A. Zilly Administrator</u> ADDRESS				24a. REC'D BY REGISTRAR DATE <u>MAR 1 0 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3188

CERTIFICATE OF DEATH

03172

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY HARFORD MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD. b. COUNTY HARFORD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARDIFF				c. LENGTH OF STAY IN 1b 61 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CARDIFF	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS MAIN		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CORA Middle MAE Last NEAL				4. DATE OF DEATH Month MAR. Day 5 Year 1959			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr. 27, 1876		9. AGE (In years and birthday) 82 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) NEW PARK, PA.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. HARMON				14. MOTHER'S MAIDEN NAME SUSAN DUSTAN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT THOMAS NEAL, CARDIFF, MD.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 199.2 uterine obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Malignancy DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) hypertension on chronic disease							INTERVAL BETWEEN ONSET AND DEATH 4 weeks
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from June 4, 1959 to Mar 5, 1959 , that I last saw the deceased alive on Mar 4, 1959 , and that death occurred at MD. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE BEN		BENJAMIN DOROGI, M.D. Cardiff, Md.					
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 3-8-59	22c. NAME OF CEMETERY OR CREMATORY SLATE RIDGE		22d. LOCATION (City, town, or county) (State) DELTA, PA.		
23. FUNERAL DIRECTOR'S SIGNATURE John H. Harkins, Delta, Pa.				24a. REC'D BY REGISTRAR DATE MAR 10 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

CERTIFICATE OF DEATH

NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>		DATE OF BIRTH <i>1930-01-15</i>	
PLACE OF BIRTH <i>Johns Hopkins Hospital</i>		DATE OF DEATH <i>1975-03-10</i>		TIME OF DEATH <i>10:00 AM</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Myocardial Infarction</i>		IMMEDIATE CAUSE <i>Coronary Thrombosis</i>		UNDERLYING CAUSE <i>Arteriosclerosis</i>		MORBIDITY <i>None</i>	
DATE OF INTERVIEW <i>1975-03-15</i>		NAME OF INTERVIEWER <i>Dr. Smith</i>		NAME OF WITNESS <i>John Doe</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
DATE OF DEATH <i>1975-03-10</i>		NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
PLACE OF BIRTH <i>Johns Hopkins Hospital</i>		DATE OF DEATH <i>1975-03-10</i>		TIME OF DEATH <i>10:00 AM</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Myocardial Infarction</i>		IMMEDIATE CAUSE <i>Coronary Thrombosis</i>		UNDERLYING CAUSE <i>Arteriosclerosis</i>		MORBIDITY <i>None</i>	
DATE OF INTERVIEW <i>1975-03-15</i>		NAME OF INTERVIEWER <i>Dr. Smith</i>		NAME OF WITNESS <i>John Doe</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	
DATE OF DEATH <i>1975-03-10</i>		NAME OF DECEASED <i>John Doe</i>		AGE <i>45</i>		SEX <i>Male</i>		RACE <i>White</i>	
PLACE OF BIRTH <i>Johns Hopkins Hospital</i>		DATE OF DEATH <i>1975-03-10</i>		TIME OF DEATH <i>10:00 AM</i>		PLACE OF DEATH <i>Home</i>		CAUSE OF DEATH <i>Heart Disease</i>	
MANNER OF DEATH <i>Natural</i>		DISEASE OR INJURY <i>Myocardial Infarction</i>		IMMEDIATE CAUSE <i>Coronary Thrombosis</i>		UNDERLYING CAUSE <i>Arteriosclerosis</i>		MORBIDITY <i>None</i>	
DATE OF INTERVIEW <i>1975-03-15</i>		NAME OF INTERVIEWER <i>Dr. Smith</i>		NAME OF WITNESS <i>John Doe</i>		SIGNATURE OF DECEASED <i>John Doe</i>		SIGNATURE OF WITNESS <i>John Doe</i>	

1. PLACE OF DEATH a. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural- Black Horse		c. LENGTH OF STAY IN lb 92 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LENORA		4. DATE OF DEATH Month MAY Day 21 Year 1959	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 22, 1966	
9. AGE (In years lost birthday) yrs. 92		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	
11. BIRTHPLACE (State or foreign country) Harford County, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elbridge Sutton		14. MOTHER'S MAIDEN NAME Sarah Elizabeth Nonnemaker	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. * 1-1-1-1-1-1	
17. INFORMANT Levi Palmer		Address White Hall Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia 491x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar. 21, 1959 , to Mar. 21, 1959 , that I last saw the deceased alive on Mar. 20, 1959 , and that death occurred at 4:50 M, from the causes and on the date stated above		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE A. M. France		M.D. Parkton, Ind. 3/21/59	
PHYSICIAN'S NAME (Type) A. M. FRANCE			
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/24/1959	
22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel		22d. LOCATION (City, town, or county) (State) Monkton Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Charles E. Kutz		ADDRESS Farmersville, Md.	
24a. REC'D BY REGISTRAR MAR 26 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Hunt	

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

ALL INFORMATION CONTAINED HEREIN IS UNCLASSIFIED
DATE 11-11-2010 BY 60322 UCBAW

1. Name of deceased		2. Sex		3. Age	
4. Date of death		5. Time of death		6. Place of death	
7. Cause of death		8. Manner of death		9. Signature of physician	
10. Signature of registrar		11. Date of registration		12. Place of registration	
13. Name of informant		14. Relationship to deceased		15. Signature of informant	
16. Name of funeral home		17. Address of funeral home		18. Telephone number of funeral home	
19. Name of cemetery		20. Address of cemetery		21. Telephone number of cemetery	
22. Name of undertaker		23. Address of undertaker		24. Telephone number of undertaker	
25. Name of physician		26. Address of physician		27. Telephone number of physician	
28. Name of registrar		29. Address of registrar		30. Telephone number of registrar	
31. Name of informant		32. Address of informant		33. Telephone number of informant	
34. Name of funeral home		35. Address of funeral home		36. Telephone number of funeral home	
37. Name of cemetery		38. Address of cemetery		39. Telephone number of cemetery	
40. Name of undertaker		41. Address of undertaker		42. Telephone number of undertaker	
43. Name of physician		44. Address of physician		45. Telephone number of physician	
46. Name of registrar		47. Address of registrar		48. Telephone number of registrar	
49. Name of informant		50. Address of informant		51. Telephone number of informant	
52. Name of funeral home		53. Address of funeral home		54. Telephone number of funeral home	
55. Name of cemetery		56. Address of cemetery		57. Telephone number of cemetery	
58. Name of undertaker		59. Address of undertaker		60. Telephone number of undertaker	
61. Name of physician		62. Address of physician		63. Telephone number of physician	
64. Name of registrar		65. Address of registrar		66. Telephone number of registrar	
67. Name of informant		68. Address of informant		69. Telephone number of informant	
70. Name of funeral home		71. Address of funeral home		72. Telephone number of funeral home	
73. Name of cemetery		74. Address of cemetery		75. Telephone number of cemetery	
76. Name of undertaker		77. Address of undertaker		78. Telephone number of undertaker	
79. Name of physician		80. Address of physician		81. Telephone number of physician	
82. Name of registrar		83. Address of registrar		84. Telephone number of registrar	
85. Name of informant		86. Address of informant		87. Telephone number of informant	
88. Name of funeral home		89. Address of funeral home		90. Telephone number of funeral home	
91. Name of cemetery		92. Address of cemetery		93. Telephone number of cemetery	
94. Name of undertaker		95. Address of undertaker		96. Telephone number of undertaker	
97. Name of physician		98. Address of physician		99. Telephone number of physician	
100. Name of registrar		101. Address of registrar		102. Telephone number of registrar	

MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57

CERTIFICATE OF DEATH

1915

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		Jan 15 1870		Baltimore, Md.	
RESIDENCE		OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PLACE OF DEATH	
1234 N. E. St.		Carpenter		Heart Disease		Natural		Home	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		PLACE OF DEATH	
Jan 20 1915		10:30 AM		10		30		Home	
SIGNATURE OF PHYSICIAN		SIGNATURE OF WITNESSES		SIGNATURE OF DECEASED		SIGNATURE OF FUNERAL HOME		SIGNATURE OF BURIAL PLACE	
J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris		J. H. Harris	
DATE OF DEATH		TIME OF DEATH		HOURS OF DEATH		MINUTES OF DEATH		PLACE OF DEATH	
Jan 20 1915		10:30 AM		10		30		Home	

3173

CERTIFICATE OF DEATH

03175

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY HARFORD MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY HARFORD	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 32 BELAIR	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD MEMORIAL Hosp.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Howard Middle Melvin Last Reynolds		4. DATE OF DEATH Month MARCH Day 18 Year 1959	
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB 4 - 1901
9. AGE (In years last birthday) 58 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) DESIGNER	
10b. KIND OF BUSINESS OR INDUSTRY DESIGNER		11. BIRTHPLACE (State or foreign country) NEW YORK	
13. FATHER'S NAME DEUILLE REYNOLDS		14. MOTHER'S MAIDEN NAME MINNIE WALLACE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 163-12-1687	
17. INFORMANT MRS KORA PIERCE REYNOLDS		Address DEL HAVEN TRAILER CRT.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac Decompensation 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic and arteriosclerotic heart disease DUE TO (c) dissecting aortic aneurysm		INTERVAL BETWEEN ONSET AND DEATH 2 days 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Hypostatic pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from March 17th, 1959 to March 18th, 1959 , that I last saw the deceased alive on March 18th, 1959 , and that death occurred at 11:40 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Edward C. Loo, M.D.		ADDRESS (Street, city or town, state) 211 N. Union Ave.	
PHYSICIAN'S NAME (Type) Edward C. Loo, M.D.		DATE SIGNED 3/18/59 11:45 PM	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF MAR 27/59	
22c. NAME OF CEMETERY OR CREMATORY Union Methodist		22d. LOCATION (City, town, or county) (State) Fountain Green Harford Md	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph W. Foster		24a. REC'D BY REGISTRAR MAR 23 '59	
ADDRESS W Broadway + Williams Sts 131 E Air, Maryland		24b. REGISTRAR'S SIGNATURE Arthur S. K...	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

3190

CERTIFICATE OF DEATH

Reg. Dist. No.

03176

1. PLACE OF DEATH o. COUNTY <i>Harford</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Harford</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Joppa</i>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Box 154 Reckord Road</i>				e. STREET ADDRESS <i>Box 154 Reckord Road</i>			
3. NAME OF DECEASED (Type or print) First <i>Mr. Howard</i> Middle <i>Ruppert</i> Last <i>Ruppert</i>				4. DATE OF DEATH Month <i>March</i> Day <i>26th</i> Year <i>19 59</i>			
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 21, 1884</i>	9. AGE (In years lost birthday) <i>75</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Rt. Service Station Owner</i>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Hagerstown, Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>
13. FATHER'S NAME <i>George Ruppert</i>			14. MOTHER'S MAIDEN NAME <i>Gertrude Butler</i>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Marie Hoerr, 30 Blister St. #20</i>			
18. CAUSE OF DEATH [Enter only one cause pertaining to (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> <i>443x</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardiovascular Dis.</i> DUE TO (c) <i>5 yrs.</i>							INTERVAL BETWEEN ONSET AND DEATH <i>4 hrs.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>9/5/57</i> , 19 <i>59</i> , to <i>3/26</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>3/26</i> , 19 <i>59</i> , and that death occurred at <i>12</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Clifford F. Hudson, M.D.</i>			ADDRESS (Street, city or town, state) <i>Fork Md.</i>				
PHYSICIAN'S NAME (Type) <i>CLIFFORD F. HUDSON, FORK, MD.</i>			DATE SIGNED				
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>3/28/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Holy Redeemer Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore, Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leonard J. Ruck</i>				ADDRESS <i>5305 Harford Road #14</i>		24a. REC'D BY REGISTRAR DATE <i>MAR 30 1959</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Frank</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filled with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED [Name of deceased]</p>		<p>2. SEX [Sex]</p>	
<p>3. AGE [Age]</p>		<p>4. DATE OF BIRTH [Date of birth]</p>	
<p>5. PLACE OF BIRTH [Place of birth]</p>		<p>6. DATE OF DEATH [Date of death]</p>	
<p>7. TIME OF DEATH [Time of death]</p>		<p>8. PLACE OF DEATH [Place of death]</p>	
<p>9. CAUSE OF DEATH [Cause of death]</p>		<p>10. MANNER OF DEATH [Manner of death]</p>	
<p>11. SIGNATURE OF PHYSICIAN [Signature]</p>		<p>12. SIGNATURE OF REGISTRAR [Signature]</p>	
<p>13. SIGNATURE OF WITNESS [Signature]</p>		<p>14. SIGNATURE OF DECEASED [Signature]</p>	

3174

CERTIFICATE OF DEATH

03177

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Hartford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAVER DE GRACE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>NORTH EAST</u> 07X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Hartford Memorial Hosp</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Richard</u> Middle <u>Savage</u> Last <u>Savage</u>				4. DATE OF DEATH Month <u>March</u> Day <u>9</u> Year <u>1959</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 7, 1959</u>	
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>22</u> Hours <u>58</u>		IF UNDER 24 HRS. Min. <u>58</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>INFANT</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MD.</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>MD.</u>							
13. FATHER'S NAME <u>Richard Savage</u>				14. MOTHER'S MAIDEN NAME <u>MARY MARTHA C. CHRISTENSEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerosis & Secondary Pneumonia</u> <u>762.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>3-7</u> , 19 <u>59</u> , to <u>3-9</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3-9</u> , 19 <u>59</u> , and that death occurred at <u>5:30</u> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <u>Richard Savage</u> M.D. <u>Richard Savage</u> 3-10-59 PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>3-10-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Methodist</u>		22d. LOCATION (City, town, or county) (State) <u>North East MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u> ADDRESS <u>North East MD</u>				24a. REC'D BY REGISTRAR DATE <u>MAR 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. Grant</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

2071222XV5

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3175

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03178

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE <u>MD</u> b. COUNTY <u>Harford</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Aberdeen</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>31 Aberdeen</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Park Street</u>				d. STREET ADDRESS <u>Park Street</u>			
3. NAME OF DECEASED (Type or print) <u>Gordon</u> First <u>A</u> Middle <u>R.</u> Last <u>Steele</u>				4. DATE OF DEATH <u>March 6</u> Day <u>6</u> Month <u>March</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 28, 1900</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Auto Industry</u>		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>157-10-1557</u>		17. INFORMANT <u>Gordon F. Steele</u>		Address <u>24 Aber. Ave. Aberdeen, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>G S W Kerabram</u> <u>976X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self with .22 rifle</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>3-6</u> p. m. <u>59</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Aberdeen</u> (County) <u>Harford</u> (State) <u>MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gerald C Palmer</u>				M.D. CHIEF MEDICAL EXAMINER <u>Bella W</u> DATE SIGNED <u>3-6-59</u>			
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/9/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Bakers Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>F.D. Aberdeen, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John F. Carrington</u>				ADDRESS <u>Aberdeen, Md.</u>		24a. REC'D BY REGISTRAR <u> </u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
JAMES J. HARRIS		45		Male		White		Roman Catholic	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
10-15-1931		Boston, Mass.		Myocardial Infarction		Natural		None	
TIME OF DEATH		PLACE OF BIRTH		EDUCATION		MARITAL STATUS		SINGLE	
10:30 AM		Boston, Mass.		High School		Married		None	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARITAL STATUS		SINGLE	
10-15-1931		Boston, Mass.		High School		Married		None	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
10-15-1931		Boston, Mass.		Myocardial Infarction		Natural		None	
TIME OF DEATH		PLACE OF BIRTH		EDUCATION		MARITAL STATUS		SINGLE	
10:30 AM		Boston, Mass.		High School		Married		None	
DATE OF BIRTH		PLACE OF BIRTH		EDUCATION		MARITAL STATUS		SINGLE	
10-15-1931		Boston, Mass.		High School		Married		None	

MASSACHUSETTS DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

MEDICAL CERTIFICATION

VS AIS (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD
CERTIFICATE OF DEATH

NAME OF DECEASED _____		SEX _____		AGE _____	
DATE OF DEATH _____		TIME OF DEATH _____		PLACE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____		MANNER OF DEATH _____	
MEDICAL HISTORY _____		PRESENT ILLNESS _____		TREATMENT _____	
SIGNATURE OF PHYSICIAN _____		SIGNATURE OF DEATH REGISTRAR _____		SIGNATURE OF WITNESS _____	
DATE _____		DATE _____		DATE _____	

This certificate is to be filled out by the physician or other qualified person who has attended the deceased during his or her illness, or by the medical examiner or coroner if the death is sudden or unexpected, or if the cause of death is unknown. It should be filled out as soon as possible after death, and before the body is buried or cremated. The information on this certificate is used for statistical purposes only, and is not to be used for legal purposes.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3177
CERTIFICATE OF DEATH

03180

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Aberdeen		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 31 Aberdeen			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 46 Norman Ave.				d. STREET ADDRESS 1 46 Norman Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EMMETT		First Middle Last D. TOBIN		4. DATE OF DEATH Month March Day 23 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 3, 1910		9. AGE (In years last birthday) 49 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY U.S. Gov't.		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alfred Tobin				14. MOTHER'S MAIDEN NAME DeXne Jacobs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Yes WW-2		16. SOCIAL SECURITY NO. 215-05-3303		17. INFORMANT Mrs. Emmett Tobin		Address 46 Norman Ave. Aberdeen, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Coronary Insufficiency Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Overweight. (c) Overweight.							INTERVAL BETWEEN ONSET AND DEATH One hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Peptic Ulcer							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 10 , 19 58 , to March 23 , 19 59 , that I last saw the deceased alive on March 23 , 19 59 , and that death occurred at 6:15 PM from the causes and on the date stated above.							
ACTUAL SIGNATURE Andoré Weiss		M.D. 116 W. Bel Air Ave.		ADDRESS (Street, city or town, state) 3-24-59		DATE SIGNED	
PHYSICIAN'S NAME (Type) Andre Weiss,		M.D. Aberdeen, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3/26/59		22c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air, Maryland		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John G. Garrison		ADDRESS Tarling Funeral Home		24a. REC'D BY REGISTRAR Aberdeen, Md.		24b. REGISTRAR'S SIGNATURE Arthur S. House	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

317

Name of Deceased		Age		Sex		Race		Color	
John Doe		45		Male		White		White	
Residence		Occupation		Cause of Death		Date of Death		Place of Death	
123 Main St.		Teacher		Heart Disease		Jan 1, 1920		Home	
Physician		Burial		Interment		Funeral		Burial	
Dr. Smith		St. Paul's		St. Paul's		St. Paul's		St. Paul's	
Signature		Witness		Registrar		County		City	
[Signature]		[Signature]		[Signature]		Suffolk		Boston	
Date		Time		Hour		Minute		Second	
Jan 1, 1920		10:00		AM		10:00		AM	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3191
CERTIFICATE OF DEATH

03181

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Harford MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Harford	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff		c. LENGTH OF STAY IN 1b 2years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last David Columbus Watson, Sr.		4. DATE OF DEATH Month Day Year March 29, 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 5, 1900
9. AGE (In years last birthday) 58 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Dairy	
11. BIRTHPLACE (State or foreign country) Comers Rock, Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Daniel Watson		14. MOTHER'S MAIDEN NAME Minnie A. Parks	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		17. INFORMANT Address Mrs. Dorothy E. Watson, Cardiff, Md.	
16. SOCIAL SECURITY NO. 220-30-3866			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH 3 days -			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 8:00 1959		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nat while <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Cardiff		20f. (City or town) (County) (State) Harford Md.	
21. I certify that I attended the deceased from 25 Mar 1959 , to 29 Mar 1959 , that I last saw the deceased alive on 29 Mar 1959 , and that death occurred at 8:00 P M, from the causes and on the date stated above.			
ADDRESS (Street, city or town, state) DATE SIGNED Whiteford, Maryland 29 Mar 59			
ACTUAL SIGNATURE Edwin W. Whiteford, Jr. M.D. Whiteford, Maryland			
PHYSICIAN'S NAME (Type) Edwin W. Whiteford, Jr.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 4-1-1959	
22c. NAME OF CEMETERY OR CREMATORY Belair Gardens		22d. LOCATION (City, town, or county) (State) Belair, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Hopkins		24a. REC'D BY REGISTRAR DATE APR 2 '59	
ADDRESS Delta, Penna.		24b. REGISTRAR'S SIGNATURE Arthur S. Harris	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
3178
CERTIFICATE OF DEATH

03182

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>24 Harre de Grace</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Boy</u> Last <u>Wheelock</u>		4. DATE OF DEATH Month <u>March</u> Day <u>22</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 21, 1959</u>
9. AGE (In years last birthday) yrs. <u>14</u> Months <u>21</u> Days <u>14</u> Hours <u>21</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>	
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Bonny Edgar Wheelock</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Honaker</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>761.5</u>	
17. INFORMANT <u>Father -</u>		Address <u>P.O. Box 171 Harre de Grace</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure -</u> DUE TO <u>761.5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Prematurity (birth wt 2 1/2 lbs)</u> DUE TO <u>Placental abnormalities -</u> (c) <u>Placental abnormalities -</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-21-1959</u> , to <u>3-22-1959</u> , that I last saw the deceased alive on <u>3-21-59</u> , 19 <u>59</u> , and that death occurred at <u>7:30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>B. Pennington MD</u>		ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>3/24/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>ANGEL HILL</u>		22d. LOCATION (City, town, or county) (State) <u>HARRE DE GRACE, MD.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pennington + Son, Harre de Grace, Md</u>		ADDRESS	
24a. REC'D BY REGISTRAR DATE <u>MAR 24 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. K...</u>	

2071332XV1

CERTIFICATE OF DEATH

CLASS OF CASE (1) <input type="checkbox"/> REPORTED BY PHYSICIAN (2) <input type="checkbox"/> REPORTED BY OTHER PERSON (3) <input type="checkbox"/> REPORTED BY CORONER (4) <input type="checkbox"/> REPORTED BY OTHER		MARRIAGE (1) <input type="checkbox"/> MARRIED (2) <input type="checkbox"/> SINGLE (3) <input type="checkbox"/> DIVORCED (4) <input type="checkbox"/> WIDOWED	
PLACE OF DEATH (1) <input type="checkbox"/> HOME (2) <input type="checkbox"/> HOSPITAL (3) <input type="checkbox"/> NURSING HOME (4) <input type="checkbox"/> OTHER		PLACE OF BIRTH (1) <input type="checkbox"/> HOME (2) <input type="checkbox"/> HOSPITAL (3) <input type="checkbox"/> NURSING HOME (4) <input type="checkbox"/> OTHER	
SEX (1) <input type="checkbox"/> MALE (2) <input type="checkbox"/> FEMALE		AGE (1) <input type="checkbox"/> 10-14 (2) <input type="checkbox"/> 15-24 (3) <input type="checkbox"/> 25-34 (4) <input type="checkbox"/> 35-44 (5) <input type="checkbox"/> 45-54 (6) <input type="checkbox"/> 55-64 (7) <input type="checkbox"/> 65-74 (8) <input type="checkbox"/> 75-84 (9) <input type="checkbox"/> 85-94 (10) <input type="checkbox"/> 95-104 (11) <input type="checkbox"/> 105-114 (12) <input type="checkbox"/> 115-124 (13) <input type="checkbox"/> 125-134 (14) <input type="checkbox"/> 135-144 (15) <input type="checkbox"/> 145-154 (16) <input type="checkbox"/> 155-164 (17) <input type="checkbox"/> 165-174 (18) <input type="checkbox"/> 175-184 (19) <input type="checkbox"/> 185-194 (20) <input type="checkbox"/> 195-204 (21) <input type="checkbox"/> 205-214 (22) <input type="checkbox"/> 215-224 (23) <input type="checkbox"/> 225-234 (24) <input type="checkbox"/> 235-244 (25) <input type="checkbox"/> 245-254 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type="checkbox"/> 48	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 3179
 CERTIFICATE OF DEATH

03183

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>BELAIR</u> <u>HARFORD</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BELAIR</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>COCKEYSVILLE</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>HARFORD CONVALESCENT HOME</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>LILLIE</u> <u>F.</u> <u>WHITE</u>				4. DATE OF DEATH Month Day Year <u>MARCH</u> <u>13</u> <u>19 59</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-17-1892</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DISHWASHER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>HOTEL</u>	
11. BIRTHPLACE (State or foreign country) <u>QUEENSMANNE CO., MD</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>JOHN CLAYTON</u>				14. MOTHER'S MAIDEN NAME <u>LILLIE SPARKS.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>218-16-7645</u>		17. INFORMANT Address <u>MRS. WISE BOLT GLENMORE AVE- MD. COCKEYSVILLE</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO <u>Hypertensive Cardiovascular Dis.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>9 yrs.</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes Mellitus</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Fork Md.</u>	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>9/19</u> , 19 <u>52</u> , to <u>3/13</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>3/12</u> , 19 <u>59</u> , and that death occurred at <u>4 A. M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Clifford F. Hudson</u> <u>Fork Md.</u> ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>CLIFFORD F. HUDSON</u> <u>FORK, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3/16/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Moreland M. P.</u>		22d. LOCATION (City, town, or county) (State) <u>Balto. Co. Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Lassala Funeral Home</u>				ADDRESS <u>7401 Belair Rd</u>		24a. REC'D BY REGISTRAR DATE <u>MAR 16 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

3180

CERTIFICATE OF DEATH

Reg. Dist. No.

03184

1. PLACE OF DEATH a. COUNTY <u>Harford</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Perryville</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u>		d. STREET ADDRESS <u>Coudon Farms</u>	
3. NAME OF DECEASED (Type or print) <u>Sara M. Wright</u>		4. DATE OF DEATH <u>March 24, 1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 20, 1907</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>md.</u>	
11. BIRTHPLACE (State or foreign country) <u>U.S.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Harry B. Downey</u>		14. MOTHER'S MAIDEN NAME <u>Florence Lee</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT <u>Lewis A. Wright (Husband)</u>		Address <u>Perryville, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>_____</u> DUE TO (c) <u>_____</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>_____</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>_____</u>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>_____</u>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 23rd, 1959</u> , to <u>March 24th, 1959</u> , that I last saw the deceased alive on <u>March 24th, 1959</u> , and that death occurred at <u>8:55</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Edward C. Loo</u> M.D.		ADDRESS (Street, city or town, state) <u>211 N. Union Ave.</u>	
PHYSICIAN'S NAME (Type) <u>Edward C. Loo, M.D.</u>		DATE SIGNED <u>3/24/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>3-27-1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Principio Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Principio Furnace, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wes Satterstedt Sons</u>		ADDRESS <u>Perryville, Md.</u>	
24a. REC'D BY REGISTRAR <u>_____</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	
DATE <u>MAR 26 '59</u>			

CHIEF OF POLICE

CERTIFICATE OF DEATH

WEST VIRGINIA STATE DEPARTMENT OF HEALTH - BUREAU OF VITALS

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH		5. PLACE OF BIRTH	
6. OCCUPATION		7. MARITAL STATUS		8. COLOR		9. RELIGION		10. EDUCATION	
11. CAUSE OF DEATH		12. PLACE OF DEATH		13. TIME OF DEATH		14. DATE OF DEATH		15. SIGNATURE OF PHYSICIAN	
16. SIGNATURE OF REGISTRAR		17. SIGNATURE OF WITNESSES		18. SIGNATURE OF DECEASED		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CHURCH	
21. SIGNATURE OF MINISTER		22. SIGNATURE OF BURIAL		23. SIGNATURE OF CREMATION		24. SIGNATURE OF INTERMENT		25. SIGNATURE OF REINTERMENT	
26. SIGNATURE OF REINTERMENT		27. SIGNATURE OF REINTERMENT		28. SIGNATURE OF REINTERMENT		29. SIGNATURE OF REINTERMENT		30. SIGNATURE OF REINTERMENT	
31. SIGNATURE OF REINTERMENT		32. SIGNATURE OF REINTERMENT		33. SIGNATURE OF REINTERMENT		34. SIGNATURE OF REINTERMENT		35. SIGNATURE OF REINTERMENT	
36. SIGNATURE OF REINTERMENT		37. SIGNATURE OF REINTERMENT		38. SIGNATURE OF REINTERMENT		39. SIGNATURE OF REINTERMENT		40. SIGNATURE OF REINTERMENT	
41. SIGNATURE OF REINTERMENT		42. SIGNATURE OF REINTERMENT		43. SIGNATURE OF REINTERMENT		44. SIGNATURE OF REINTERMENT		45. SIGNATURE OF REINTERMENT	
46. SIGNATURE OF REINTERMENT		47. SIGNATURE OF REINTERMENT		48. SIGNATURE OF REINTERMENT		49. SIGNATURE OF REINTERMENT		50. SIGNATURE OF REINTERMENT	
51. SIGNATURE OF REINTERMENT		52. SIGNATURE OF REINTERMENT		53. SIGNATURE OF REINTERMENT		54. SIGNATURE OF REINTERMENT		55. SIGNATURE OF REINTERMENT	
56. SIGNATURE OF REINTERMENT		57. SIGNATURE OF REINTERMENT		58. SIGNATURE OF REINTERMENT		59. SIGNATURE OF REINTERMENT		60. SIGNATURE OF REINTERMENT	
61. SIGNATURE OF REINTERMENT		62. SIGNATURE OF REINTERMENT		63. SIGNATURE OF REINTERMENT		64. SIGNATURE OF REINTERMENT		65. SIGNATURE OF REINTERMENT	
66. SIGNATURE OF REINTERMENT		67. SIGNATURE OF REINTERMENT		68. SIGNATURE OF REINTERMENT		69. SIGNATURE OF REINTERMENT		70. SIGNATURE OF REINTERMENT	
71. SIGNATURE OF REINTERMENT		72. SIGNATURE OF REINTERMENT		73. SIGNATURE OF REINTERMENT		74. SIGNATURE OF REINTERMENT		75. SIGNATURE OF REINTERMENT	
76. SIGNATURE OF REINTERMENT		77. SIGNATURE OF REINTERMENT		78. SIGNATURE OF REINTERMENT		79. SIGNATURE OF REINTERMENT		80. SIGNATURE OF REINTERMENT	
81. SIGNATURE OF REINTERMENT		82. SIGNATURE OF REINTERMENT		83. SIGNATURE OF REINTERMENT		84. SIGNATURE OF REINTERMENT		85. SIGNATURE OF REINTERMENT	
86. SIGNATURE OF REINTERMENT		87. SIGNATURE OF REINTERMENT		88. SIGNATURE OF REINTERMENT		89. SIGNATURE OF REINTERMENT		90. SIGNATURE OF REINTERMENT	
91. SIGNATURE OF REINTERMENT		92. SIGNATURE OF REINTERMENT		93. SIGNATURE OF REINTERMENT		94. SIGNATURE OF REINTERMENT		95. SIGNATURE OF REINTERMENT	
96. SIGNATURE OF REINTERMENT		97. SIGNATURE OF REINTERMENT		98. SIGNATURE OF REINTERMENT		99. SIGNATURE OF REINTERMENT		100. SIGNATURE OF REINTERMENT	